

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN1303	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/02/2010
NAME OF PROVIDER OR SUPPLIER TRI STATE HEALTH AND REHABILITATION CE			STREET ADDRESS, CITY, STATE, ZIP CODE 600 SHAWANEE RD HARROGATE, TN 37752		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	<p>Initial Comments</p> <p>Complaint investigation #TN00026064 was completed on August 27, 2010, at Tri State Health and Rehabilitation Center. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.</p> <p>Complaint #TN00026064</p>		N 000		

Division of Health Care Facilities

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6599

UPON11

If continuation sheet 1 of 1